

TRICARE PRIME SUPPLEMENTAL ENROLLMENT FORM INSTRUCTIONS

Thank you for choosing TRICARE Prime. Please print all information in ink and fill out the form accurately and completely. Your application will be delayed if your family information is incomplete or does not match the DEERS file. If you are unsure of how to answer a question, please call our toll-free telephone number 1-888-999-5195. Our Beneficiary Services Representatives will be happy to assist you.

- 1-2. Self-explanatory
3. Family Member information - List information for all family members who are enrolling in the TRICARE Prime program. **MUST** select Primary Care Manager to enroll. Please state two (2) Primary Care Manager choices for each Prime member. SMHS will assign a Primary Care Manager if your first and second choice cannot be honored. If enrolling more than two (2) family members, use another form.
4. Have all beneficiaries, age 17 and older, completed a Health Enrollment and Assessment Review form (HEAR)? Check the appropriate box.
5. Does the Sponsor or eligible Family Members have other health insurance coverage, including Medicare?
6. Is any family member requesting enrollment participating in the Program For Persons With Disabilities (PFPWD)?
7. Read the acknowledgement. Sign and date application form and indicate relationship to sponsor.

Important:
Return White and Pink copies in enclosed envelope. The Yellow copy should be retained as proof of intent to enroll. Enrollment is subject to eligibility, Primary Care Manager assignment and all other TRICARE regulations. Upon completion of the enrollment process, a Prime identification card will be mailed to you. In the meantime, please use this copy.

Please mail your supplemental application to the following address: SMHS Enrollment, PO Box 828450
Philadelphia, PA 19101-9415

Your completed application form will be processed, and a Prime enrollment card will be mailed to each eligible family member. The effective date of membership will be indicated on each card.

AGENCY DISCLOSURE STATEMENT: Public reporting of this collection of information is estimated to average 15 minutes per application, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to the Department of Defense, to Washington Headquarters Services, Directorate of Information Operations and Reports, 1216 Jefferson Davis Highway, Suite 1204, Arlington, VA 92202-4802; and the Office of Management and Budget, Paperwork Reduction Project 0720-0008, Washington DC 20508.

PRIVACY ACT STATEMENT: (1) 44 USC 8101; 10 USC 1079 and 1086, 38 USC 613; EO 9397. (2) Purpose: To evaluate for medical care provided by civilian sources to Military Health System beneficiaries applying for coverage under the TRICARE Program (82 CFR, Part 199.17). (3) Uses: Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS): to the Department of Justice for representation of the Secretary of Defense in civil actions: and to Congressional Offices in response to inquiries made in the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program. (4) Disclosure: Voluntary; however, failure to provide information will result in the denial of enrollment.

EBD:

FAMILY MEMBER INFORMATION	1) Sponsor's Name Last First MI 2) Sponsor's Social Security Number									
	3) Name Last First MI Relationship to Sponsor									
	If spouse, are you retired from the military? <input type="checkbox"/> Yes <input type="checkbox"/> No			Social Security Number		Birthdate		Mo Day Yr		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Street or P.O. Box		Apt. No.		City		State		Zip Code Phone ()	
	Family Member's 1st Choice - Primary Care Manager <input type="checkbox"/> Military Treatment Facility Team <input type="checkbox"/> Civilian Physician									
	List 1st Choice Primary Care Manager's Complete Address						Is this your current physician? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Family Member's 2nd Choice - Primary Care Manager <input type="checkbox"/> Military Treatment Facility Team <input type="checkbox"/> Civilian Physician									
	List 2nd Choice Primary Care Manager's Complete Address						Is this your current physician? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Name Last First MI Relationship to Sponsor									
	If spouse, are you retired from the military? <input type="checkbox"/> Yes <input type="checkbox"/> No			Social Security Number		Birthdate		Mo Day Yr		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Street or P.O. Box		Apt. No.		City		State		Zip Code Phone ()	
	Family Member's 1st Choice - Primary Care Manager <input type="checkbox"/> Military Treatment Facility Team <input type="checkbox"/> Civilian Physician									
List 1st Choice Primary Care Manager's Complete Address						Is this your current physician? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Family Member's 2nd Choice - Primary Care Manager <input type="checkbox"/> Military Treatment Facility Team <input type="checkbox"/> Civilian Physician										
List 2nd Choice Primary Care Manager's Complete Address						Is this your current physician? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name Last First MI Relationship to Sponsor										
If spouse, are you retired from the military? <input type="checkbox"/> Yes <input type="checkbox"/> No			Social Security Number		Birthdate		Mo Day Yr		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street or P.O. Box		Apt. No.		City		State		Zip Code Phone ()		
Family Member's 1st Choice - Primary Care Manager <input type="checkbox"/> Military Treatment Facility Team <input type="checkbox"/> Civilian Physician										
List 1st Choice Primary Care Manager's Complete Address						Is this your current physician? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Family Member's 2nd Choice - Primary Care Manager <input type="checkbox"/> Military Treatment Facility Team <input type="checkbox"/> Civilian Physician										
List 2nd Choice Primary Care Manager's Complete Address						Is this your current physician? <input type="checkbox"/> Yes <input type="checkbox"/> No				
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List 2nd Choice Primary Care Manager's Complete Address						Is this your current physician? <input type="checkbox"/> Yes <input type="checkbox"/> No				
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Street or P.O. Box		Apt. No.		City		State		Zip Code Phone ()		
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Family Member's 2nd Choice - Primary Care Manager <input type="checkbox"/> Military Treatment Facility Team <input type="checkbox"/> Civilian Physician										
List 2nd Choice Primary Care Manager's Complete Address						Is this your current physician? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4) Have all non-active duty beneficiaries, age 17 or older, completed a Health Enrollment and Assessment Review (HEAR) form? <input type="checkbox"/> Yes <input type="checkbox"/> No										
5) Other Health Insurance (OHI)										
Policy Number:_____ Insurance Company Name:_____										
Effective Dates: From_____To_____ Type of Coverage <input type="checkbox"/> Family <input type="checkbox"/> Individual Policy Type: <input type="checkbox"/> Champus Supplemental <input type="checkbox"/> Commercial <input type="checkbox"/> Employer GRP										
Policy Holder Name: _____ (Last) _____ (First) _____ (Middle) Policy Holder SSN: _____ - _____ - _____										
Patient Name: _____ (Last) _____ (First) _____ (Middle)										
Relationship to Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Former Spouse <input type="checkbox"/> Child Pharmacy Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No										
6) Is any family member requesting enrollment participating in the Program For Persons With Disabilities (PFPWD)? <input type="checkbox"/> Yes <input type="checkbox"/> No										
If yes, please list participants:										
7) I have read the information on benefits and restrictions of the TRICARE Prime program provided me. I understand the restrictions as stated or explained to me and hereby apply for enrollment. I understand that I must choose a Primary Care Manager (PCM) participating in TRICARE Prime or select a military hospital, clinic or dispensary, when available, as my Primary Care Site to be covered by the Plan. If I decide to obtain care which has not been coordinated by my PCM and authorized by a Health Care Finder, or seek services from a non-TRICARE Prime provider, I understand that TRICARE Prime coverage will not apply and I will be responsible for payment under the Point-of-Service option for all services received. I understand that I must pay an initial and annual non-refundable enrollment fee if the sponsor is retired/deceased. I understand that enrollment is subject to verification of funds. I understand I must remain enrolled in TRICARE Prime for 12 consecutive months. I understand that my entitlement to TRICARE benefits will be confirmed through the Defense Enrollment Eligibility Reporting System (DEERS). I authorize the Plan to obtain, examine, disclose and copy records of any physician, hospital or provider when necessary for proper payment of benefits for all enrollees listed on this document; this form serves as Medical Records Release. A photographic copy of this authorization shall be as valid as the original. I hereby certify that the information provided on this document is true and complete. I agree to abide by the provisions of membership. I must disenroll from TRICARE Prime when I am no longer eligible or move from the TRICARE Prime regions. The Plan will not discriminate, or have the effect of discriminating, against any beneficiaries on the basis of health status, age, race, sex, family size, sponsor status or sponsor rank. I understand that I may be asked to waive travel access standards to seek medical treatment.										
I UNDERSTAND ENROLLMENT FEES ARE NOT REFUNDABLE.										
Please review the Agency Disclosure and the Privacy Act on the attached cover sheet before using.										
Signature _____ Relationship to Sponsor _____ Date _____										
AUTHORITY: 10 U.S.C. Chapter 55 CHAMPUS PRINCIPAL PURPOSES: Enrollment in the TRICARE Prime program. ROUTINE USES: Verify eligibility and produce enrollment cards. DISCLOSURE IS VOLUNTARY. Failure to provide the information could result in denial of reimbursement under the CHAMPUS program.										
Please return white and pink copies, retain yellow copy for your records.										
TRI-00032-1										